



Claim received for EMMA B VERRILL  
Reference # 7651222097017  
ID U44694605

THIS IS NOT A BILL

## Claim detail

CIGNA received this claim on August 7, 2012 and processed it on August 11, 2012.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/Deductible	What your plan paid	% paid	Coinsurance*	See notes
MERCY HSP, Reference # 7651222097017										
07/30/12	DRUGS	20.15	2.01	0.00	18.14	0.00	14.51	80	3.63	C
Total		\$20.15	\$2.01	\$0.00	\$18.14	\$0.00	\$14.51		\$3.63	

\* After you have met your deductible, the costs of covered expenses are shared by you and your health plan.  
The percentage of covered expenses you are responsible for is called coinsurance.

## Other important information that I need to know

FINAL PAYMENT DETERMINATION WILL FOLLOW THE REVIEW OF AVAILABLE FUNDS IN A CIGNA HEALTHCARE HEALTH SAVINGS ACCOUNT OR FLEXIBLE SPENDING ACCOUNT.

## Notes

C - CUSTOMER: THANK YOU FOR USING CIGNA'S OPEN ACCESS PLUS NETWORK. THE TOTAL SHOWN IS HOW MUCH YOU SAVED. YOU DON'T NEED TO PAY THAT AMOUNT. IF YOU ALREADY PAID THE FULL AMOUNT, PLEASE ASK YOUR HEALTH CARE PROFESSIONAL FOR A REFUND. HEALTH CARE PROFESSIONAL: YOUR CIGNA AGREEMENT DOES NOT ALLOW YOU TO BILL THE PATIENT FOR THE DIFFERENCE. IF YOU ARE IN INDIANA, CALIFORNIA OR TENNESSEE, PLEASE CONTACT CIGNA CUSTOMER SERVICE AT 1.800.88CIGNA (882.4462) FOR INFORMATION ON YOUR DISCOUNTED RATE.

## Additional appeal information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to [http://www.cigna.com/privacy/privacy\\_healthcare\\_forms.html](http://www.cigna.com/privacy/privacy_healthcare_forms.html) or call the Customer Service number on the back of your ID card.

If you are not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.askebsa.dol.gov](http://www.askebsa.dol.gov). Assistance may also be available through the below consumer assistance or ombudsman program(s):

State	Contact Information
Maine	Consumer for Affordable Health Care, 12 Church Street, PO Box 2490, Augusta, ME 04338-2490 (800) 965-7476 <a href="http://www.maineahc.org">www.maineahc.org</a> <a href="mailto:consumerhealth@maineacahc.org">consumerhealth@maineacahc.org</a>



Connecticut General Life Insurance Company AS AGENT FOR AMERICAN RED CROSS

ANNE VERRILL  
214 MORTON ROAD  
YARMOUTH ME 04096-5706

**Customer service**

Call the number on the back of your ID card or  
**(855) 272-7677**

**www.myCIGNA.com**

*If you have any questions about this document,  
please call Customer Service at the number  
above. Please have your reference number ready.*

**Service date**

July 30, 2012

**Reference # / ID**

7651222097017 / U44694605

**Account name / Account #**

AMERICAN RED CROSS / 3334660

**THIS IS NOT A BILL.**

Your health care professional may bill you directly  
for any amount that you owe.

## Explanation of benefits

for a claim received for EMMA B VERRILL, Reference # 7651222097017

### Summary of a claim for services on July 30, 2012

for services provided by MERCY HSP

Amount Billed	\$20.15	This was the amount that was billed for your visit on 07/30/2012.
Discount	\$2.01	<b>You saved \$2.01.</b> CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	\$14.51	Your plan paid \$14.51 to MERCY HSP.
What I owe	<b>\$3.63</b>	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.
You saved	<b>81%</b>	You saved \$16.52 (or 81%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit <a href="http://www.myCIGNA.com">www.myCIGNA.com</a> or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.



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**Service date**

August 8, 2012

**Reference # / ID**

7651222897525 / U44694605

**Account name / Account #**

AMERICAN RED CROSS / 3334660

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Your health care professional may bill you directly  
for any amount that you owe.

## Explanation of benefits

for a claim received for EMMA B VERRILL, Reference # 7651222897525

### Summary of a claim for services on August 8, 2012

for services provided by QUEST DIAG CAMBRIDGE

Amount Billed	\$47.84	This was the amount that was billed for your visit on 08/08/2012.
Discount	\$43.48	<b>You saved \$43.48.</b> CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	\$3.49	Your plan paid \$3.49 to QUEST DIAG CAMBRIDGE.
What I owe	<b>\$0.87</b>	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.
You saved	<b>98%</b>	You saved \$46.97 (or 98%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit <a href="http://www.myCIGNA.com">www.myCIGNA.com</a> or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.





Claim received for EMMA B VERRILL  
 Reference # 7651222096889  
 ID U44694605

THIS IS NOT A BILL

## Claim detail

CIGNA received this claim on August 7, 2012 and processed it on August 9, 2012.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What your plan paid	% paid	Coinsurance*	See notes
WALTER F KELLER DO, Reference # 7651222096889										
07/16/12	PHYSICIAN	160.27	88.51	0.00	71.76	0.00	57.41	80	14.35	A
<b>Total</b>		<b>\$160.27</b>	<b>\$88.51</b>	<b>\$0.00</b>	<b>\$71.76</b>	<b>\$0.00</b>	<b>\$57.41</b>		<b>\$14.35</b>	

\* After you have met your deductible, the costs of covered expenses are shared by you and your health plan.  
 The percentage of covered expenses you are responsible for is called coinsurance.

## What I need to know for my next claim

You've paid a total of \$3,552.44 toward your \$6,000 out of network deductible for 2012  
 Your \$3,000 in network deductible has been met for 2012  
 You've paid a total of \$4,335.55 toward your \$22,000 out of network out of pocket expenses for 2012  
 You've paid a total of \$4,335.55 toward your \$11,000 in network out of pocket expenses for 2012

## Other important information that I need to know

PAYMENT FROM YOUR CHOICE FUND HSA IS NOT A DETERMINATION IF THESE ARE QUALIFIED EXPENSES UNDER FEDERAL TAX LAW. PLEASE CONSULT YOUR TAX ADVISOR.

## Notes

A - CUSTOMER: THANK YOU FOR USING CIGNA'S OPEN ACCESS PLUS NETWORK. THE TOTAL SHOWN IS HOW MUCH YOU SAVED. YOU DON'T NEED TO PAY THAT AMOUNT. IF YOU ALREADY PAID THE FULL AMOUNT, PLEASE ASK YOUR HEALTH CARE PROFESSIONAL FOR A REFUND. HEALTH CARE PROFESSIONAL: YOUR CIGNA AGREEMENT DOES NOT ALLOW YOU TO BILL THE PATIENT FOR THE DIFFERENCE. IF YOU ARE IN INDIANA, CALIFORNIA OR TENNESSEE, PLEASE CONTACT CIGNA CUSTOMER SERVICE AT 1.800.88CIGNA (882.4462) FOR INFORMATION ON YOUR DISCOUNTED RATE.



Connecticut General Life Insurance Company AS AGENT FOR AMERICAN RED CROSS

ANNE VERRILL  
214 MORTON ROAD  
YARMOUTH ME 04096-5706

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*If you have any questions about this document,  
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above. Please have your reference number ready.*

**Service date**

August 3, 2012

**Reference # / ID**

7651222091828 / U44694605

**Account name / Account #**

AMERICAN RED CROSS / 3334660

**THIS IS NOT A BILL.**

Your health care professional may bill you directly  
for any amount that you owe.

## Explanation of benefits

for a claim received for EMMA B VERRILL, Reference # 7651222091828

### Summary of a claim for services on August 3, 2012

for services provided by BYRAM HLTHCARE CTRS INC

Amount Billed	\$580.20	This was the amount that was billed for your visit on 08/03/2012.
Discount	\$403.32	<b>You saved \$403.32.</b> CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	\$141.50	Your plan paid \$141.50 to BYRAM HLTHCARE CTRS INC.
What my accounts paid	\$35.38	\$35.38 was paid from your Health Savings Account (HSA).
What I owe	<b>\$0.00</b>	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.

**You saved**

**93%**

You saved \$544.82 (or 93%) off the total amount billed. This is a total of your discount and what your plan paid.

To maximize your savings, visit [www.myCIGNA.com](http://www.myCIGNA.com) or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.





Claim received for EMMA B VERRILL  
Reference # 7651222091828  
ID U44694605

THIS IS NOT A BILL

## Claim detail

CIGNA received this claim on August 6, 2012 and processed it on August 9, 2012.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/Deductible	What your plan paid	% paid	Coinsurance*	See notes
BYRAM HLTHCARE CTRS INC, Reference # 7651222091828										
08/03/12	SUPPLIES	580.20	403.32	0.00	176.88	0.00	141.50	80	35.38	A
Total		\$580.20	\$403.32	\$0.00	\$176.88	\$0.00	\$141.50		\$35.38	

\* After you have met your deductible, the costs of covered expenses are shared by you and your health plan.  
The percentage of covered expenses you are responsible for is called coinsurance.

## What I need to know for my next claim

You've paid a total of \$3,552.44 toward your \$6,000 out of network deductible for 2012  
Your \$3,000 in network deductible has been met for 2012  
You've paid a total of \$4,306.85 toward your \$22,000 out of network out of pocket expenses for 2012  
You've paid a total of \$4,306.85 toward your \$11,000 in network out of pocket expenses for 2012

## Other important information that I need to know

PAYMENT FROM YOUR CHOICE FUND HSA IS NOT A DETERMINATION IF THESE ARE QUALIFIED EXPENSES UNDER FEDERAL TAX LAW. PLEASE CONSULT YOUR TAX ADVISOR.

## Notes

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YARMOUTH ME 04096-5706

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above. Please have your reference number ready.*

**Service dates**

May 29, 2012 - May 31, 2012

**Reference # / ID**

7651221790139 / U44694605

**Account name / Account #**

AMERICAN RED CROSS / 3334660

**THIS IS NOT A BILL.**

Your health care professional may bill you directly  
for any amount that you owe.

## Explanation of benefits

for a claim received for EMMA B VERRILL, Reference # 7651221790139

### Summary of a claim for services on May 29, 2012 - May 31, 2012

for services provided by ROBIN S SMITH PT

Amount Billed	\$1,125.00	This was the amount that was billed for your visit on 05/29/2012 through 05/31/2012.
Discount	\$0.00	CIGNA negotiates discounts with health care professionals and facilities to help you save money. Using an in-network option is one way you can save. Visit myCIGNA.com or call Customer Service to learn more.
Amount not covered	\$445.40	This is the portion of your bill that's not covered by your plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information.
What your plan paid	\$0.00	Your plan paid \$0.00.
What my accounts paid	\$78.44	\$78.44 was paid from your Health Savings Account (HSA).
What I owe	\$0.00	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.





Claim received for EMMA B VERRILL  
 Reference # 7651222897525  
 ID U44694605

**THIS IS NOT A BILL**

## Claim detail

CIGNA received this claim on August 15, 2012 and processed it on August 17, 2012.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ What your plan Deductible	% paid	Coinsurance*	See notes
QUEST DIAG CAMBRIDGE, Reference # 7651222897525									
08/08/12	LABORATORY	47.84	43.48	0.00	4.36	0.00	3.49	80	0.87 A
<b>Total</b>		<b>\$47.84</b>	<b>\$43.48</b>	<b>\$0.00</b>	<b>\$4.36</b>	<b>\$0.00</b>	<b>\$3.49</b>	<b>\$0.87</b>	

\* After you have met your deductible, the costs of covered expenses are shared by you and your health plan.  
 The percentage of covered expenses you are responsible for is called coinsurance.

## What I need to know for my next claim

You've paid a total of \$2,658.18 toward your \$6,000 out of network deductible for 2012  
 You've paid a total of \$2,658.18 toward your \$3,000 IN NETWORK DEDUCTIBLE for 2012  
 You've paid a total of \$3,482.97 toward your \$22,000 out of network out of pocket expenses for 2012  
 You've paid a total of \$3,482.97 toward your \$11,000 in network out of pocket expenses for 2012

## Other important information that I need to know

FINAL PAYMENT DETERMINATION WILL FOLLOW THE REVIEW OF AVAILABLE FUNDS IN A CIGNA HEALTHCARE HEALTH SAVINGS ACCOUNT OR FLEXIBLE SPENDING ACCOUNT.

## Notes

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Connecticut General Life Insurance Company AS AGENT FOR AMERICAN RED CROSS

ANNE VERRILL  
214 MORTON ROAD  
YARMOUTH ME 04096-5706

**Customer service**

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(855) 272-7677

[www.myCIGNA.com](http://www.myCIGNA.com)

*If you have any questions about this document,  
please call Customer Service at the number  
above. Please have your reference number ready.*

**Service date**

August 3, 2012

**Reference # / ID**

7651222898683 / U44694605

**Account name / Account #**

AMERICAN RED CROSS / 3334660

**THIS IS NOT A BILL.**

Your health care professional may bill you directly  
for any amount that you owe.

## Explanation of benefits

for a claim received for EMMA B VERRILL, Reference # 7651222898683

### Summary of a claim for services on August 3, 2012

for services provided by BOHDAN POMAHAC MD

Amount Billed	\$338.00	This was the amount that was billed for your visit on 08/03/2012.
Discount	\$106.95	<b>You saved \$106.95.</b> CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	\$184.84	Your plan paid \$184.84 to BOHDAN POMAHAC MD.
What my accounts paid	\$46.21	\$46.21 was paid from your Health Savings Account (HSA).
What I owe	<b>\$0.00</b>	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.
You saved	<b>86%</b>	You saved \$291.79 (or 86%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit <a href="http://www.myCIGNA.com">www.myCIGNA.com</a> or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.

# KCI USA, INC. Proof of Delivery / Assignment of Benefits

Rental Order: 18145779  
Work Order: 63969573  
Order Type: Delivery



<b>Ship to:</b> VERRILL, EMMA 2864624 214 MORTON RD  YARMOUTH ME04096  <b>HHA:</b> MASSACHUSETTS GENERAL HOSPITAL <b>Contact:</b> ( ) -	<b>Account Information</b> <b>Bill to:</b> CARECENTRIX 647380 111 FOUNDERS PLAZA STE 801  EAST HARTFORD CT 06108 <b>Insurance ID # - HICN:</b> U44694605-04	<b>Payor Code</b> Managed Care  <b>Billing Office</b> KCI
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<b>Patient Name:</b> EMMA VERRILL <b>Patient Location:</b> HOME <b>Drop Ship to:</b>	<b>Patient Order Information</b> <b>Patient Phone:</b> (207) 632-4720 <b>Caller Name:</b> DAVID FITZ <b>Caller Phone:</b> (207) 775-3446 <b>Caller Date:</b> 08/02/2012 <b>Request Date:</b> 08/08/2012	<b>Time:</b> 10:58 CST <b>Time:</b> 10:30 LST
<b>Drop Ship Location:</b> <b>Drop Ship Contact:</b>		

<b>Product:</b> VAC ActivAC (2) ActiVAC Canister w/Gel (5ea) M8275058/5	<b>Serial #:</b> VCQK11364 (3) STRAC Lge GranuFoam Dress(5) M8275053/5	<b>Bar Code #:</b> VCQK11364
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<b>Special Instructions</b>
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PATIENT COPY

1. I give KCI USA, Inc. ("KCI") the right to bill for and receive insurance payments for my medical care and I direct my insurance company, Medicare, Medicaid, and any other entity paying for my medical care ("my insurer") to pay KCI directly for the equipment and supplies provided to me.
2. I understand that ownership of the equipment shall at all times remain the property of KCI USA, Inc, unless I qualify for and agree to purchase the equipment. KCI shall have the right to inspect the equipment wherever the same may be and that I may be responsible for the replacement value of the KCI rental product in the event it is lost, damaged, or stolen while in my possession or control.
3. I understand that my insurer may need information about my medical condition to make a decision about making payments to KCI. This information may be maintained by my physician, home healthcare agency, medical facility, employer, or other entities. I authorize any holder of medical information about conditions for which I am being treated to release that information to KCI and insurer.
4. I understand that I am responsible for reading, signing, and returning the Assignment of Benefits form to KCI USA, Inc.; if not returned, I assume full responsibility of all financial charges associated to my therapy treatment provided by KCI USA, Inc.
5. I understand that KCI, my insurer, healthcare provider and other entities involved in my medical care may need certain individually identifiable financial or health information to assist in my care. I agree that such information may be used and disclosed by KCI, my insurer, healthcare providers, and other entities for purposes of treatment, payment, healthcare operations or as otherwise permitted by law. I understand that additional information on types of uses and disclosures that may be made are contained in KCI's Notice of Privacy Practices. I understand that I may revoke my consent at any time if I do so in writing, except to the extent such consent has already been relied upon.
6. For Medicare/Medicaid Beneficiaries: I understand that I am responsible for any and all deductibles or co-payments established by Medicare or Medicaid. This information has been explained to me.
7. For all other Insurance Coverage: I understand that I am responsible for all deductibles, co-payments, or other amounts established by my insurance company, as well as all charges for non-covered services provided to me by KCI. This information has been explained to me.
8. I have received a copy of the Patient Information Guide (including: KCI's Notice of Privacy Practices, Supplier Standards (for Medicare) and product information and instructions.
9. I understand the care and utilization of this product and know that I can contact KCI USA, Inc. at (1-800-275-4524) for additional information.
10. In the event that my insurer pays me directly, I agree to forward all payments to KCI USA, Inc., P.O. Box 203084, Houston, TX, 77216-3084.
11. I understand: (i) KCI has the option to provide new or used equipment; (ii) that I shall not modify or alter the equipment; (iii) that I will notify KCI immediately of any equipment problems; (iv) that the equipment is only to be used upon the order and direction of my doctor; (v) that the equipment is only to be used with KCI authorized disposables (i.e., dressings).
12. I understand that the equipment rental charges will continue until the date I call KCI USA, Inc. at (1-800-275-4524) to pick up the rental product

**Additional Terms Governing Use, Return, and Payment:**

- i. In the event of patient's default in payment, or the default of patient's insurer, health benefit plan or other third party payor, KCI shall be entitled to recover the equipment and shall not be liable to the patient or to the patient's representatives or heirs for any injury or damage resulting from the discontinuation of treatment with the equipment.
- ii. KCI shall be entitled to all expenses, court costs, and reasonable attorney fees for the collection of any patient responsibility amounts that are past due and to enforcement of this AOB. All past amounts shall bear interest at the lesser of 1.5% per month or at the highest rate permitted by law.
- iii. This AOB and any dispute arising out of the goods and services provided shall be governed and construed according to the laws of the State of Texas without regard to its conflict of laws provision, and venue shall lie exclusively with a court of proper jurisdiction in Texas. Any dispute arising out of this Agreement shall be resolved by binding arbitration in accordance with the rules of the Judicial Arbitration and Mediation Services (JAMS).

<b>Patient Name:</b> EMMA VERRILL	<b>Patient Signature:</b> x	<b>Date:</b>
<b>Authorized Agent Sig. (if Pt. Unable to Sign)</b>	<b>Date</b>	<b>Relationship to Pt.</b>
<b>By:</b>	<b>Reason Pt. Unable to Sign</b>	
<b>Authorized Agent Address</b>		<b>Phone</b>
<b>Print Name of Person Signing</b>	<b>KCI Rep Name</b>	<b>Date</b> <b>Time</b>



Claim received for EMMA B VERRILL  
 Reference # 7651221591565  
 ID U44694605

**THIS IS NOT A BILL**

## Claim detail

CIGNA received this claim on August 1, 2012 and processed it on August 7, 2012.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/Deductible	What your plan paid	% paid	Coinsurance*	See notes
MERCY HSP, Reference # 7651221591565										
07/23/12	DRUGS	20.15	2.01	0.00	18.14	0.00	14.51	80	3.63	A
<b>Total</b>		<b>\$20.15</b>	<b>\$2.01</b>	<b>\$0.00</b>	<b>\$18.14</b>	<b>\$0.00</b>	<b>\$14.51</b>		<b>\$3.63</b>	

\* After you have met your deductible, the costs of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.

## Notes

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## Additional appeal information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to [http://www.cigna.com/privacy/privacy\\_healthcare\\_forms.html](http://www.cigna.com/privacy/privacy_healthcare_forms.html) or call the Customer Service number on the back of your ID card.

If you are not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.askebsa.dol.gov](http://www.askebsa.dol.gov). Assistance may also be available through the below consumer assistance or ombudsman program(s):

State	Contact Information
Maine	Consumer for Affordable Health Care, 12 Church Street, PO Box 2490, Augusta, ME 04338-2490 (800) 965-7476 <a href="http://www.maineahc.org">www.maineahc.org</a> <a href="mailto:consumerhealth@mainecahc.org">consumerhealth@mainecahc.org</a>



Connecticut General Life Insurance Company AS AGENT FOR AMERICAN RED CROSS

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YARMOUTH ME 04096-5706

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please call Customer Service at the number  
above. Please have your reference number ready.*

**Service date**

July 30, 2012

**Reference # / ID**

7651222096721 / U44694605

**Account name / Account #**

AMERICAN RED CROSS / 3334660

**THIS IS NOT A BILL.**

Your health care professional may bill you directly  
for any amount that you owe.

## Explanation of benefits

for a claim received for EMMA B VERRILL, Reference # 7651222096721

### Summary of a claim for services on July 30, 2012

for services provided by WALTER F KELLER DO

Amount Billed	\$144.90	This was the amount that was billed for your visit on 07/30/2012.
Discount	\$73.14	<b>You saved \$73.14.</b> CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	\$57.41	Your plan paid \$57.41 to WALTER F KELLER DO.
What my accounts paid	\$14.35	\$14.35 was paid from your Health Savings Account (HSA).
What I owe	<b>\$0.00</b>	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.
You saved	<b>90%</b>	You saved \$130.55 (or 90%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit <a href="http://www.myCIGNA.com">www.myCIGNA.com</a> or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.



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